Medicine in Society

The Concept of Mainstream Medicine For All Californians

Fifth Progress Report of Committee On Role of Medicine in Society

PART I

This Fifth Progress Report is to be printed in three parts in CALIFORNIA MEDICINE. *Following the appearance of Part III the report will be bound in a pamphlet which may be ordered at $1 a copy from 693 Sutter Publications, Inc., 693 Sutter Street, San Francisco, California 94102.*

*"A profession has for its prime object the service it can render to humanity"**

THIS REPORT is presented as a logical sequel to the earlier progress reports of the Committee on the Role of Medicine in Society. Its thesis is that if "the American people are committed to a policy of one-class, one-door, high quality medical care available to all, to the limits of our resources, without discrimination on the basis of race, creed, color or economic circumstances," as Anne Somers has stated,† then by definition and de facto this can only be "mainstream medicine." This *Fifth Progress Report* therefore assumes that "mainstream medicine" as we know it today can and must undergo whatever changes are necessary for it to become the instrument through which the national purpose in health care will be achieved. This report will seek to analyze the present situation and to develop in broad outline some of the actions and programs which probably will be necessary in order to reach the goal of "Mainstream Medicine for All Californians."

The previous reports of the Committee provide much of the background upon which this study and its recommendations are based.

¶ **The First Progress Report** (March 1964) established goals for the Committee and recommended "that the policy of the California Medical Association and of the medical profession of the nation be that of assuring every individual of good medical care by doctors of medicine,

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**Percival's Medical Ethics*, edited by C. D. Leake, Williams and Wilkins, Baltimore, 1927, p. 257.

†Anne Somers, J. Med. Ed., 43:479, April 1968.

and the availability of such professional care when he or she needs it."

¶ **The Second Progress Report** (January 1965) called upon the medical profession to identify with the total medical care problems of society, present creative and constructive programs, strive for a greater consensus within itself, try to revitalize the meaning of the physician-patient relationship and inculcate social roles and responsibilities into the educational process.

¶ **The Third Progress Report** (April 1967) examined the emergence of the concept of health care as a human right and identified certain principles with respect to this which appeared to have general acceptance; recognized the central importance of quality in health care; developed a description of high quality health care, and proposed that a "Quality Assessment Index for Health Care" based on this description be developed; analyzed the strengths and weakness of a "partnership" of medicine with government in a pluralistic society and proposed that medicine's position be strengthened in four specific areas; probed the contemporary scene with respect to organizing for health care, and suggested that perhaps the time had come to encourage the establishment of a "National Academy of Medicine."

¶ **The Fourth Progress Report** (April 1968) noted the infinite scope of the national commitment to health care and finite resources available for this purpose; identified certain value systems which will be applied in decisions concerning allocation of resources; proposed a role of flexible and informed advocacy for organized medicine to bring its knowledge and expertise more effectively to bear in today's pluralistic society and called for an appropriate definition of health, a more precise delineation of the national purpose, and of the scope and responsibility of medicine with respect to this purpose.

Since the last progress report of the Committee a national forum on "The Scope and Responsibility of Medicine" was conducted in CALIFORNIA MEDICINE and a statement on the subject, prepared from published and unpublished contributions, appeared in the December 1968 issue of that journal.

Comprehensive Health Care

It is clear that "comprehensive health care" also needs definition, but it is not yet clear precisely what this term means. Both the concept and the definition are still evolving. But one can already sense that comprehensive health care is to be equally accessible to all; to be health, rather than disease, oriented; of high quality, and that it will provide a continuum of services rather than episodic care. At its heart there should be a significant relationship between doctor and patient and ready access to the whole spectrum of health care services for every patient. One suspects that comprehensive health care will include not only personal health care, but community, environmental and species health care much as these defined in "The Scope and Responsibility of Medicine" (CALIFORNIA MEDICINE, 109:509-514, 1968).

Whatever its ultimate scope and however it may eventually be defined, it is "comprehensive health care" which "mainstream medicine" must gear itself to render to all Californians. The overall dimensions of this challenge are certainly obvious enough even though a generally accepted definition may not yet be available.

The Mainstream Concept

As nearly as the Committee can determine the use of the term "mainstream" to apply to medical care originated within the California Medical Association. A CMA statement issued in 1965 indicates that the term was already in wide usage. The following are quotations from this statement:

"When physicians link the word 'mainstream' with medical care, the implication is that all persons, regardless of age, race or economic status *should* have the assurance of having available to them the same necessary health and medical care resources which are available to the public generally. It is not to be better or less, it is to be the same. Embodied in this concept of 'mainstream' is the idea that care should be available on a continuous and comprehensive basis, not fragmented or sporadic."

* * *

"Optimum availability, accessibility and acceptability, maximum economy and maximum quality standards, as well as optimum adaptability to various social, economic and geographic circumstances are best achieved in the 'mainstream' concept, with access to all available forms of services, regardless of source of payment."

* * *

" 'Mainstream' medical care implies the maintenance of one's dignity while sick, as contrasted with the 'poor house' approach to health care. 'Mainstream' medical care means help near one's home so that a patient need not travel, for example, 100 miles to a county hospital for treatment of a broken hip. 'Mainstream' medical care envisions health facilities and services better planned for and used by all of the people of the community on the basis of their needs and requirements, rather than on the basis of income or resources."

* * *

This is the "mainstream" concept. It is voluntary and cooperative in emphasis. It relies more on motivation than compulsion. It is responsive to individual and local needs and situations. Mainstream medicine is dedicated to ensuring equal access, a single level of high quality health services and portability of protection in health care. To accomplish all this will require not only substantial effort at the local level, but also some kind of broad framework of voluntary guidelines within which solutions can be found to local and special problems and responses made to technologic and social change.

The remainder of this report addresses itself to how mainstream medicine as we know it today can be fashioned into an instrument to deliver this "comprehensive health care" to every one who

needs it and thus make "mainstream medicine for all Californians" a reality.

Some Facts for Today and Tomorrow

The Committee believes that there are a number of facts which must be taken into account which are certain to influence health care delivery to a substantial degree for the foreseeable future:

1. A disparity between the demand and expectations for health care and the resources available for its delivery exists and may be considered permanent for practical purposes.
2. The shortage of physicians will continue indefinitely and may also be considered permanent for practical purposes.
3. There will never be enough specialists in general or family practice produced to act as primary physicians for more than a minority of citizens.
4. The incentives are and will continue to be insufficient to attract physicians in the numbers needed for isolated or deprived communities.
5. Universal coverage for all persons for health care, through either the private or public sector or some combination thereof, is an inescapable corollary to the right of access of all to high quality health care.
6. Financing for health care, from whatever source or sources, will always tend to fall short of increasing demands which result from population growth and technologic progress.
7. Value judgments of one sort or another will determine the allocation of relatively scarce resources and services, and moral, humanitarian, social, economic and political pressures may be anticipated at all levels of health care.

The Committee believes that these are among the basic conditions to which mainstream medicine must adjust and within which it must develop itself to provide comprehensive health care for all Californians. The Committee also believes that the present climate is such that no rigid single system of health care can be imposed by government or anyone else, although efforts to do just this are now being made and will surely continue. The play is in the hands of the private sector and the next moves are up to it. It now becomes necessary to try to identify some of the barriers which must be overcome, the tools which are available to mainstream medicine, and the means by which the tools may be applied to overcome the barriers and provide better solutions.

The Barriers

There is much in the literature about the barriers to equal access of all to health care services and there are many suggestions for overcoming them. (A bibliography will be supplied at end of Part III of this study.) It is unfortunate but true that in general more problems have been exposed than have so far been solved. The Committee suggests that most of these barriers can be lumped in several categories as follows:

1. *The Definition of the Scope of the Problem*

It has not been possible, and indeed it may well never be possible, to define precisely what should be the content or subject matter of comprehensive health care, or to quantitate the true demand for this care or to estimate the resources which are or will be needed to render it. These will always be undergoing change because of technologic progress and changes in the numbers, needs and expectations of consumers.

2. *The Interface where Consumer Meets the System*

Many barriers exist at the point where health care is, or should be, sought and received. The evidence is accumulating that personal interest in the consumer and consumer participation are both necessary at these points of contact. The essence of understanding and personal trust inherent in the traditional doctor-patient relationship must somehow be brought to bear at the interface where the consumer meets the system, even though this may be done through aides or intermediaries.

3. *The Marketing of Mainstream Medicine*

Mainstream medicine today is not the "non-system" claimed by some of its detractors, but rather its system has failed to reach and win acceptance from major segments of the population. The structure of mainstream medicine needs some alteration for better distribution, as well as better packaging and more aggressive marketing if it is to overcome these barriers and improve consumer acceptance and utilization.

4. *Insufficient Resources*

The quantitative insufficiency of resources in manpower, facilities and equipment are and will remain barriers to reaching the national goal, and the situation is not improved when citizens and their government are slow to provide the wherewithal to increase these resources as they are needed.

5. *Shortages of Dollars*

It is unreasonable to expect that all the dollars needed can ever be assigned to health care and their comparative lack will therefore always be a barrier to the quality as well as to the quantity and availability of services. It will be necessary to combat this by improving methods of identifying what quality and quantity of services are needed, exposing and correcting waste and inefficiency in governmental and non-governmental programs and negotiating for sufficient funding from public and private sources.

6. *Organizational Inertia*

Organizations and institutions of various kinds often develop considerable inherent inertia and are at a disadvantage when the environment with which they must react changes more rapidly than they are capable of adapting to meet the changes. This may occur in business, professional, educational and governmental organizations. It has been happening in both public and private sectors with respect to health care and the barriers which result from this are considerable.

The Tools

The Committee believes that mainstream medicine already has the essential tools which will be needed but that these tools will require much wider and more imaginative use than has been the case to date if the goal of "mainstream medicine for all Californians" is to be even approximately reached. Like the barriers, the Committee sug-

gests that the tools can be lumped into a number of broad categories as follows:

1. *Data Base*

Accurate facts are among the most essential tools. The Bureau of Research and Planning has pioneered accurate data gathering for the CMA. The value of this tool has been demonstrated many times. Data retrieval is expected to contribute substantially to the data base of mainstream medicine. These should be developed and other instruments should be created as necessary to provide mainstream medicine with an accurate data base.

2. *Information Transfer*

Information transfer or communications is an important set of tools which includes not only professional education and continuing education, health education and public information, public relations, and internal communications, but also an increasing involvement on a participation basis with consumers, community organizations, all aspects of the health care industry, and government. This information transfer is a two-way street and should be considered sensory as well as motor in character. There is need for greater coordination of information transfer in some sort of nerve center.

3. *Aids and Assistants*

The already wide use of mechanical aids and professional and technical assistants in patient care and throughout the health care industry can be extended further as productivity, economy and efficiency require. The principle of delegation of responsibility and authority by physicians to their various assistants is well established in mainstream medicine and its extension should be encouraged rather than viewed with alarm.

4. *Experiment and Innovation*

Experiment and innovation have characterized mainstream medicine. This has been demonstrated in the development of various methods of financing and of new kinds of delivery systems for health care services in California and elsewhere. When soundly based on facts and an accurate assessment of the problem to be solved, experiment and innovation are the approaches most likely to produce successful solutions. Mainstream medicine should build upon its experience and encourage new approaches to the new problems which must be solved in order to achieve the national goals in health care in our pluralistic society.

5. *Advocacy and Accountability*

Since it may be anticipated that health care will usually, if not always, be comparatively underfinanced, with resources in manpower facilities and equipment less than what is needed to fulfill the public demands and expectations, mainstream medicine will usually, if not always, tend to be on the defensive unless it assumes a public role of advocating what is necessary and accounting to the public for what it has and has not been able to accomplish with the resources actually available. Mainstream medicine must have public understanding and support for its efforts if it is to achieve this goal, and its advocacy and accountability must be clear and in the public interest.

6. *Guidelines and Peer Review*

Experience with guidelines and peer review has proven their value in establishing a level of quality or efficiency without setting inflexible minimum standards which so often turn out to be the maximum level as well as the minimum standard. The CMA has had considerable experience with the use of both guidelines and peer review and these are tools which can be further developed to provide an overall framework for one level of high quality health care throughout California, while at the same time allowing for the local option, local control and local solutions for local problems which are essential to mainstream medicine. (See Part II.)

Summary of Part I

In this section of the report the Committee sought to (1) establish that "mainstream medicine" is in fact the only instrument which for practical purposes can be developed to render "comprehensive health care" for all Californians; (2) describe something of the climate or situational environment in which this will have to be accomplished; (3) assess briefly some of the obstacles to be combatted; and (4) identify some of the tools at the disposal of "mainstream medicine" which can be further developed to make this health care more nearly a reality for all Californians.

The subsequent section (Part II) will address itself to certain tasks of critical and immediate importance which appear to require concentrated study and prompt development. Part III will propose a comprehensive program for organized medicine in California.

(Part II will be published in the next issue.)